

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Elizabeth					Antal	2-27-68			1A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Mar. 7, 1905		62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Hungary		U.S.A.				TAILOT			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON			Memorial			Housewife		None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Caroline Henderson					None	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Michael Toth			Mary Nani						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			None			Louis Antal Henderson, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypokalemia, cause not determined 279X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2867 Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Trever					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-27-68		
22d. PHYSICIAN'S NAME (Type) Robert W. Trever					M.D.		22e. ADDRESS Easton, Maryland		2/27/68
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		2-29-68		Greensboro		Greensboro, Maryland			
24. FUNERAL DIRECTOR Address					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
J. E. Bouclain Greensboro, Md.					MAR 1 1968		[Signature]		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03163										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03145									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last FANNIE Biger										2 Month Day Year 2 14 68										25 27 M									
3. SEX F			4. RACE W			5. DATE OF BIRTH JAN 13, 1887			6. AGE (In years last birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH TALBOT																				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Memorial Hosp. Tal			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SUPERVISOR			12b. KIND OF BUSINESS OR INDUSTRY CLOTHING																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY CAROLINE			13c. CITY OR TOWN DENTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
14. FATHER'S NAME First Middle Last JOHN SELIN			15. MOTHER'S MAIDEN NAME First Middle Last FRANCES JOSEPHHECK			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT Address MISS HELEN SELIN DENTON, MD.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>331X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 31 hours																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ASC</u>																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>68</u> , to <u>2-19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Stephen P. Carney</u>			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-20-68																				
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney			22e. ADDRESS Easton, Maryland			22f. DATE 2/20/68																							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE FEB 22, 1968			23c. NAME OF CEMETERY OR CREMATORY DENTON			23d. LOCATION (City or Town) (County) (State) DENTON CAR. MD.																				
24. FUNERAL DIRECTOR <u>Virgil Morrison</u>			ADDRESS Denton			25a. REC'D BY REGISTRAR DATE FEB 26 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>																				

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03165

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03146

1. DECEASED NAME (Type or print) MARY ELIZABETH Breeding			2a. DATE OF DEATH Month Feb. Day 1 Year 1968			2b. HOUR 6:50 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-12-91		6. AGE (in years last birthday) 76	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT	
10. CITY OR TOWN OF DEATH EASTON, MD.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) at home		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CHARLOTTE		13c. CITY OR TOWN DENTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First JAMES H. Middle NICHOLS Last ANNIE		15. MOTHER'S MAIDEN NAME First ANNIE Middle TRICE Last TRICE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT MRS CESAR COALLA		Address DENTON, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4369 DUE TO, OR AS A CONSEQUENCE OF. (b) Recent stroke DUE TO, OR AS A CONSEQUENCE OF (c) 3398							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Anemia due to chronic gastrointestinal bleeding 4 yrs							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan , 1967, to 1 Feb , 1968, that (I) (we) last saw the deceased alive on 31 Jan 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen O. Campbell				DEGREE ATTENDING PHYS.		22c. DATE SIGNED 2-2-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE FEB 04, 1968		23c. NAME OF CEMETERY OR CREMATORY DENTON		23d. LOCATION (City or Town) (County) (State) DENTON CAR. MD	
24. FUNERAL DIRECTOR Charles Moore		ADDRESS Denton Md.		25a. REC'D BY REGISTRAR FEB 7 1968		25b. REGISTRAR'S SIGNATURE Charles Moore	

STATE OF MICHIGAN

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Mary Nashold Bowman						Month Day Year		9P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		
Female	White	8-16-1917	50 YRS					Month Day Year		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
Virginia		U.S.A.				Caroline DOA Talbot		930 M		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial			Housewife		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Caroline Greensboro				YES		So. Main	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Harrison Nashold			Annie M. Hooper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No			Unknown		Heath Bowman Greensboro, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of cerebral Arterial Aneurysm sec										
DUE TO, OR AS A CONSEQUENCE OF									?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Aneurysm of right Carotid artery just inside the skull										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Arteriosclerosis									75 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Was driving a car but loss of control of car not due driving mishap										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
CAUSE OF DEATH		HOUR A.M. P.M.		19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED						
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER								
Harold B. Plummer M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Reston Carolien Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2-24-68		Greensboro		Greensboro, Maryland				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J. E. Bouleis Greensboro, Md.						DATE FEB 27 1968		Charles Judge		

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03166										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03147									
CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) <i>Robert Leon Brinsfield</i>										2a. DATE OF DEATH Month <i>2</i> Day <i>26</i> Year <i>68</i>										2b. HOUR <i>5:30</i> P. M.									
3. SEX <i>male</i>					4. RACE <i>white</i>					5. DATE OF BIRTH <i>6-25-21</i>					6. AGE (In years last birthday) <i>46</i> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>					7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <i>Talbot</i> Md.														
10. CITY OR TOWN OF DEATH <i>Easton</i>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>unk.</i>					12b. KIND OF BUSINESS OR INDUSTRY <i>unk.</i>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>					13b. COUNTY <i>Talbot</i>					13c. CITY OR TOWN <i>Easton</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <i>113 Park Street</i>									
14. FATHER'S NAME First <i>Herman M.</i> Middle <i>Brinsfield</i> Last <i></i>										15. MOTHER'S MAIDEN NAME First <i>Inez</i> Middle <i>Jones</i> Last <i></i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <i>219-07-3357</i>					17. INFORMANT Address <i>Mrs. Inez Brinsfield, Easton, Md.</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>680.1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Concomitant of milk</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>680.1</i>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>E.C.H. Schmidt</i>					22c. DATE SIGNED <i>27 Feb 68</i>					22d. PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>																			
22e. ADDRESS <i>Easton, Md.</i>																													
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE <i>2/29/68</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>					23d. LOCATION (City or Town) (County) (State) <i>Easton, Talbot, Md.</i>														
24. FUNERAL DIRECTOR <i>Ray D. Haverhill</i> ADDRESS <i>Easton, Md.</i>										25a. REC'D BY REGISTRAR DATE <i>FEB 29 1968</i>					25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

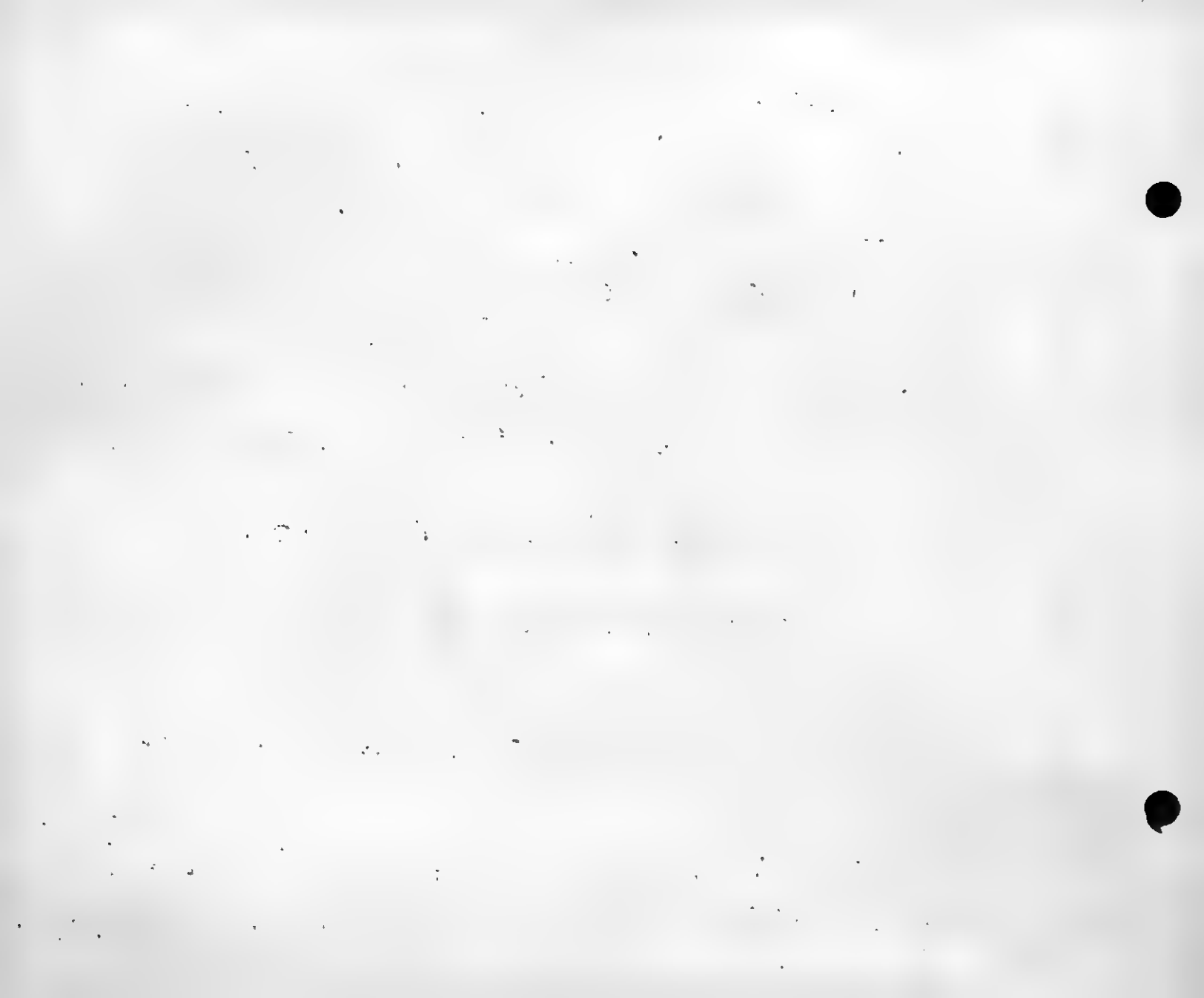
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03148

1 DECEASED NAME (Type or print) Howard			First Middle Last CLARK			2a. DATE OF DEATH Month Day Year 2-10-68			2b. HOUR 1:15 AM			
3 SEX M		4 RACE W		5. DATE OF BIRTH MAY 20, 1883			6. AGE (In years last birthday) 84 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH TALBOT Md					
10. CITY OR TOWN OF DEATH EASTON				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY CHARLOTTE		13c. CITY OR TOWN HICKMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14 FATHER'S NAME First Middle Last PAUL CLARK				15 MOTHER'S MAIDEN NAME First Middle Last SARA JONES								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17 INFORMANT Address MRS. DOLAS MITCH, SMYRNA, DEL.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONSOLIDATIVE RIGHT LUNG PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) FAR ADVANCED PUL. TUBERCULOSIS DUE TO, OR AS A CONSEQUENCE OF (c) UNKN. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WKS.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION 2-8-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TO ASSIST RESPIRATIONS AND REMOVE LUNG SECRETION				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 2-7-68 , 19 68 , to 2-10-68 , 19 68 , that (I) (we) lost saw the deceased alive on 2-10-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Richard Tyson						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-10-68				
22d. PHYSICIAN'S NAME (Type) RICHARD TYSON						22e. ADDRESS 221 GLENWOOD AVE. EASTON MD. - 21601						
23a. BURIAL CREMATION, REMOVAL BURIAL		23b. DATE FEB 13, 1968		23c. NAME OF CEMETERY OR CREMATORY HOLLYWOOD		23d. LOCATION (City or Town) (County) (State) HARROGTON TOWNSHIP, DEL.						
24. FUNERAL DIRECTOR John						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John				
DATE FEB 16 1968												

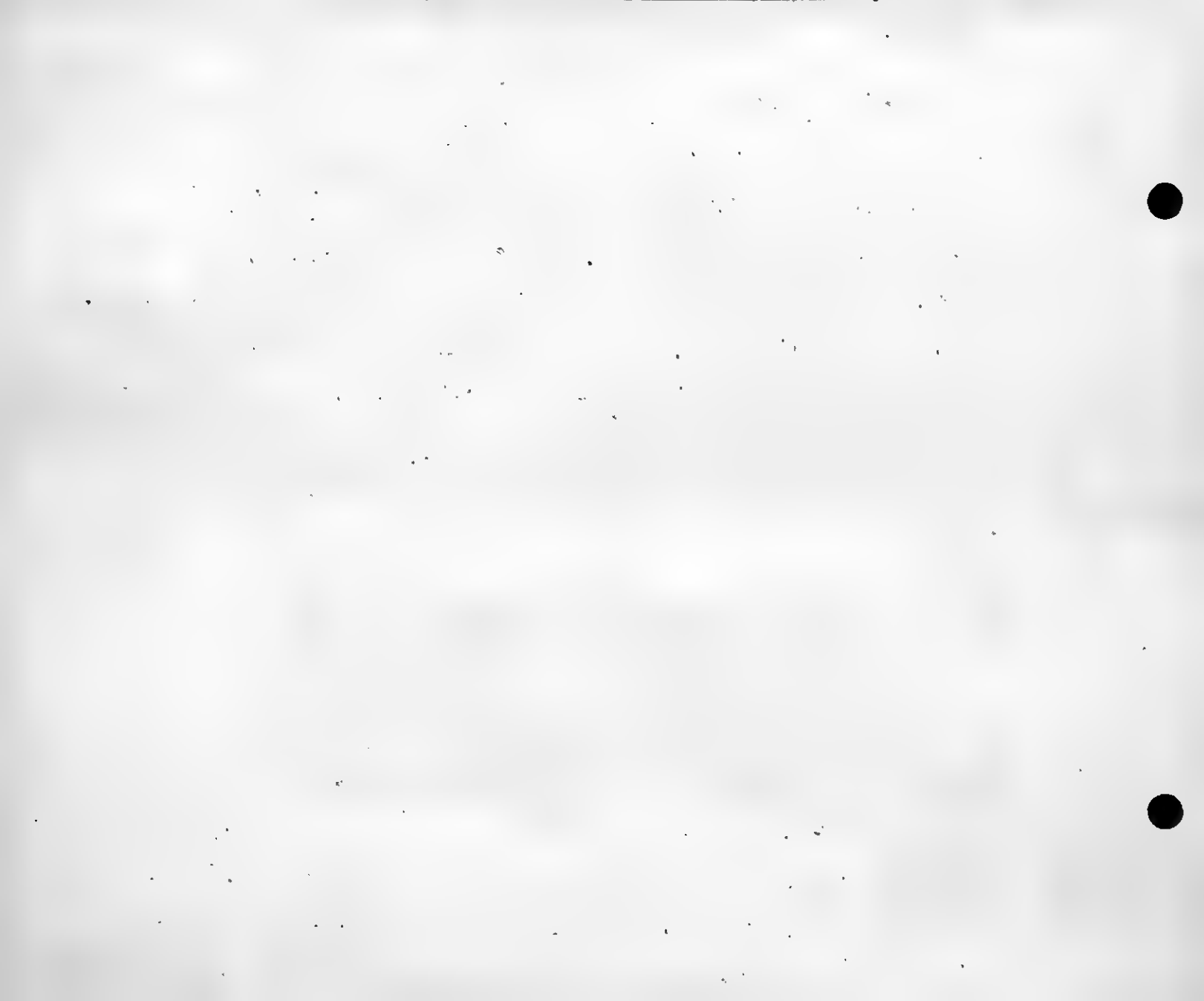


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Kenneth Robert Colburn</i>			2a DATE OF DEATH Month <i>B</i> Day <i>68</i> Year <i>1968</i>			2b HOUR <i>5:15</i> MIN <i>P</i>			
3. SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>8/20/1921</i>		6 AGE (In years last birthday) <i>46</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i>	
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
10 CITY OR TOWN OF DEATH <i>EASTON</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>METNORRIL HOSPITAL</i>		12a USUAL OCCUPATION (Kind of work done during/last of working life, even if retired) <i>POLICE MAN</i>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>MARYLAND</i>		13b COUNTY <i>TALBOT</i>		13c CITY OR TOWN <i>EASTON</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>420 S. HARRISON ST.</i>	
14 FATHER'S NAME First <i>JOSEPH</i> Middle <i>C.</i> Last <i>COLBURN</i>			15 MOTHER'S MAIDEN NAME First <i>ETHEL</i> Middle <i>GREEN</i> Last <i>HAWK</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>N</i>			16b SOCIAL SECURITY NO <i>214-07-0308</i>		17 INFORMANT Address <i>MRS. KENNETH COLBURN, EASTON, MD.</i>				
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <i>Feb 13</i> 19 <i>68</i> , to <i>19</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb 13</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>E. C. N. Schmidt</i>		22c. PHYSICIAN'S NAME (Type) <i>E. C. N. Schmidt</i>		22a. ADDRESS <i>Easton, Md. 21601</i>		22c. DATE SIGNED <i>14 Feb 68</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE <i>2/17/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>OXFORD</i>		23d. LOCATION (City or Town) (County) (State) <i>OXFORD, MD</i>			
24 FUNERAL DIRECTOR <i>Maurice E. Williams</i>		25a. REC'D BY REGISTRAR <i>James Judge</i>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		DATE <i>FEB 16 1968</i>			

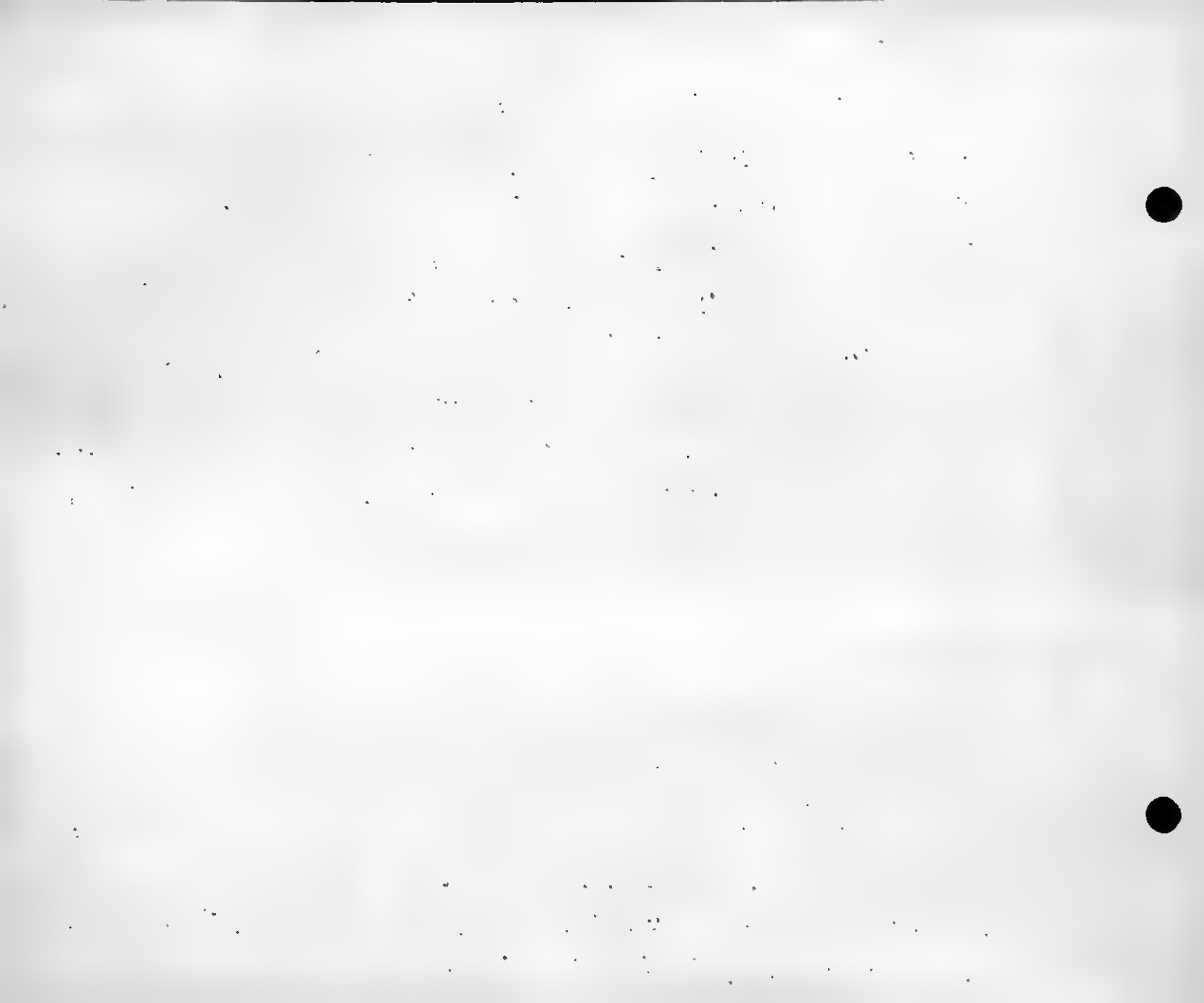


CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Roger Ross Dolby			2a. DATE OF DEATH Month 2 Day 1 Year 68			2b. HOUR 6:05 P.M.											
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 6/2/1904			6. AGE (In years last birthday) 62 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Talbot Md.								
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) Farmer			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY Dor.			13c. CITY OR TOWN HURLOCK			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Broad St					
14. FATHER'S NAME First Hiram Middle J Last Dolby			15. MOTHER'S MAIDEN NAME First Lillian Middle Ross Last Dolby			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO.			17. INFORMANT Dr. Roger R. Dolby, Hurlock MD 21643					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 5 yrs																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
MEDICAL CERTIFICATION																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1-19 , 19 68 , to Feb , 19 68 , that (I) (we) last saw the deceased alive on 1 Feb , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Stephen P. Carney			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-3-68								
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.			22e. ADDRESS Easton, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/4/68			23c. NAME OF CEMETERY OR CREMATORY East New Market			23d. LOCATION (City or Town) (County) (State) East New Market Dor, Md								
24. FUNERAL DIRECTOR Howard H. Willoughby			ADDRESS East New Market			25a. REC'D BY REGISTRAR FEB 7 1968			25b. REGISTRAR'S SIGNATURE [Signature]								

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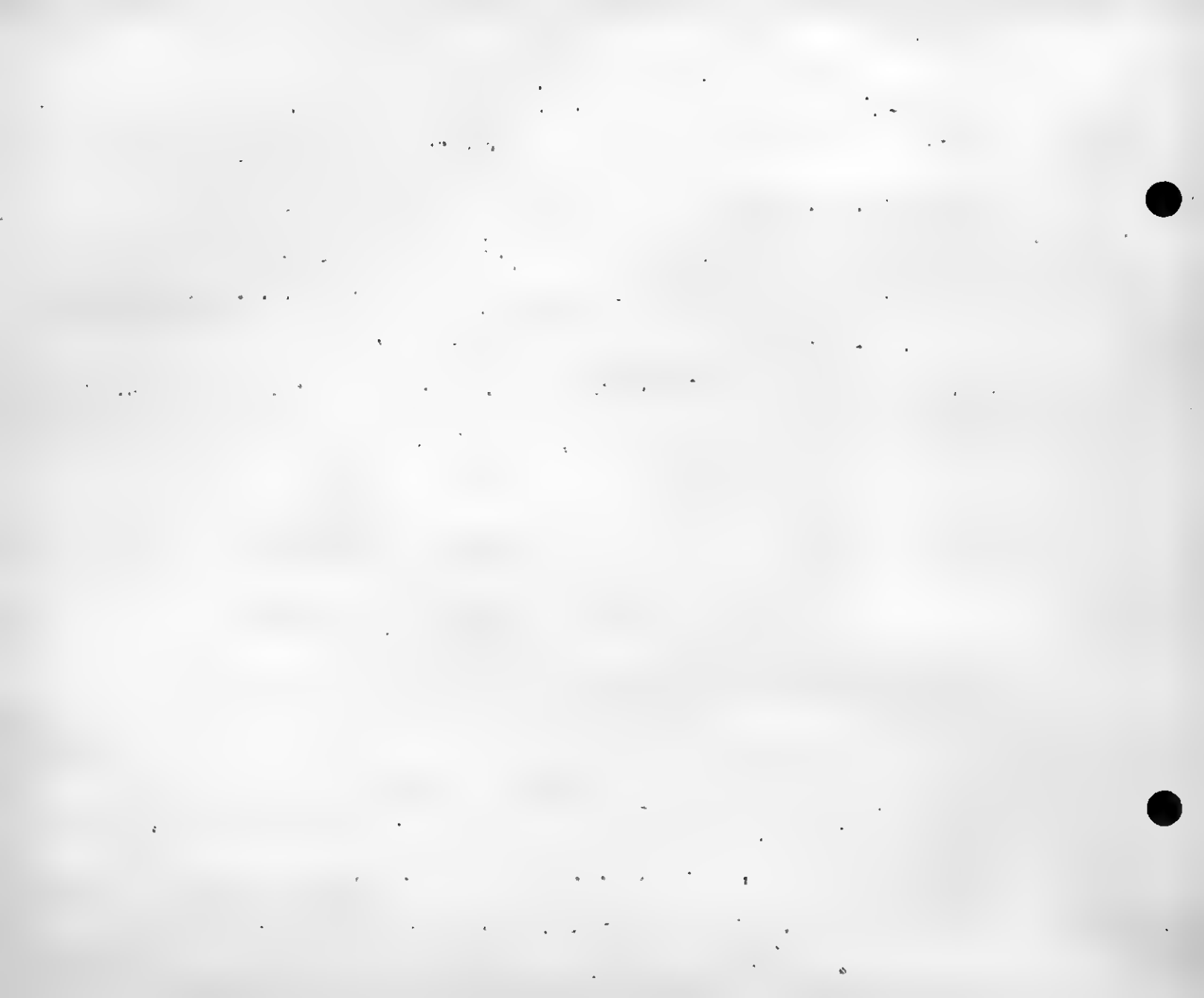
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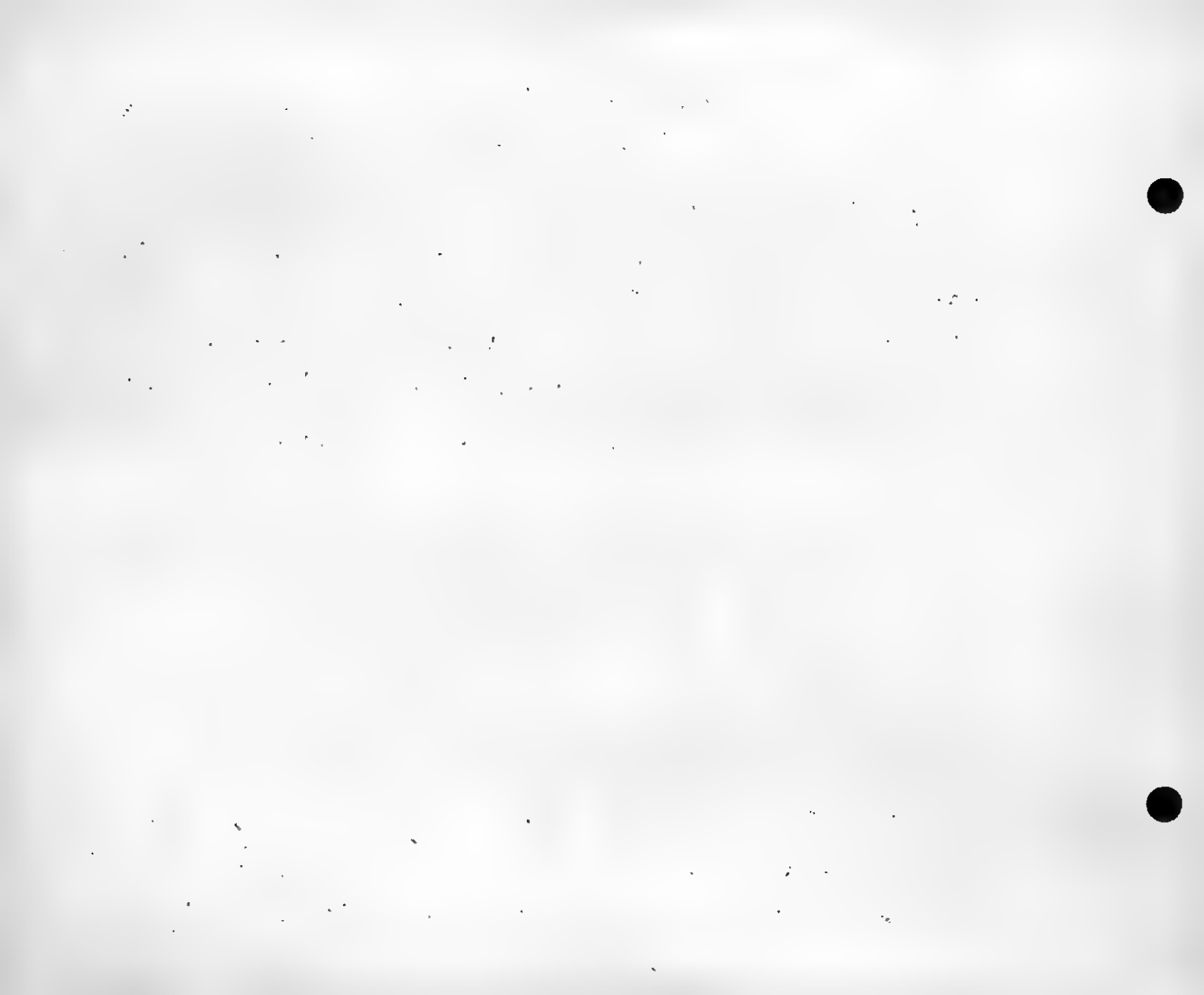
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) LAWRENCE FRANKLIN FLUHARTY					2a. DATE OF DEATH Month 2 Day 5 Year 68		2b. HOUR 9:47 AM		
3 SEX Male		4. RACE White		5. DATE OF BIRTH October 21, 1910		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS 5 DAYS 10	
7a. BIRTHPLACE (State or foreign country) Caroline Co., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. #2, Box 141	
14. FATHER'S NAME First J. Middle Franklin Last Fluharty					15. MOTHER'S MAIDEN NAME First Bessie Middle Love Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-14-3218		17. INFORMANT Address Mrs. Roberta Fluharty, Preston, Md., RFD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) +									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 5, 1968 , to Feb 5, 1968 , that (I) (we) last saw the deceased alive on Feb 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen P. Carney DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-6-68			
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 9, 1968		23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery		23d. LOCATION (City or Town) (County) (State) Preston, Maryland			
24. FUNERAL DIRECTOR A. J. Hampton ADDRESS Federalburg, Md.				25a. REC'D BY REGISTRAR FEB 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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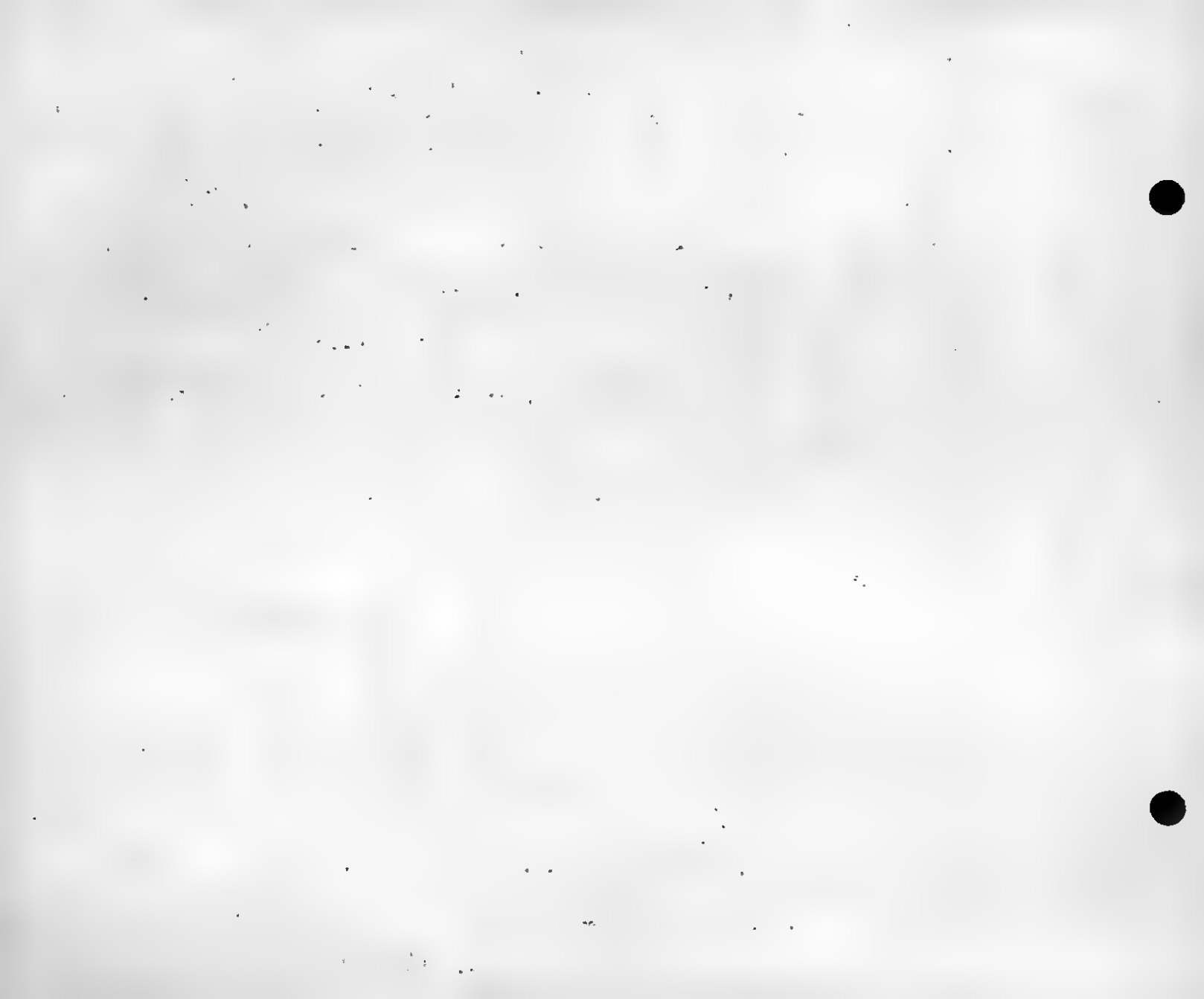
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
James Franklin Haddaway						2 Month 18 Day 68 Year 11 1/2 M				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		
male		white		January 18, 1897		71 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		USA				Talbot Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hospital			Waterman		Seafood		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Talbot		Heavitt					
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
William James Haddaway						Carmelia Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT Address					
Yes			WWI		213-24-0303 Edge W. Haddaway St. Michaels, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) Lymphoblastic Lymphoma										
2021 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION				
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE						22c. DATE SIGNED				
E. C. H. Schmidt						19 Feb 68				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
E. C. H. Schmidt						Easton, Maryland.				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial			Feb 21, 1967		Heavitt Cemetery		Heavitt, Maryland			
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Harrison Leonard St. Michaels Md						FEB 23 1968		Charles Jones		



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Addie			ADDIE	N.	HIGNUTT	2 Month 9 Day 68 Year			5 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female		White		September 28, 1872		95 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				Talbot Md					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton			Memorial Hospital			Housework		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission)			13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Caroline		Federalsburg				205 Vesper Avenue		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
John Henry Hignutt						Edna Flowers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address		
No			None			Mrs. Gertie Still, Federalsburg, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia									5 days		
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure									3 weeks		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4341											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Asthma											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No		City or Town		County	State
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 7 Feb, 1968, to 9 Feb, 1968, that (I) (we) saw the deceased alive on Feb 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
Stephen P. Carney		M.D.		22d. ADDRESS		2/12/68					
22d. PHYSICIAN'S NAME (Type)											
Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Feb. 12, 1968		Hill Crest Cemetery		Federalsburg, Maryland							
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Franklin Funeral Home		Federalsburg, Md		FEB 16 1968		John J. Jones					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00173

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

23154

1. DECEASED NAME (Type or print) HARRY VERNON HUTSON			2a. DATE OF DEATH Month February Day 8 Year 1968			2b. HOUR 12:30 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 17, 1910		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 M.N.	
7a. BIRTHPLACE (State or foreign country) Queen Anne's Co.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot County Md.			
10. CITY OR TOWN OF DEATH Bozman		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ----		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Waterman		12b. KIND OF BUSINESS OR INDUSTRY Seafood			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Bozman		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ----	
14. FATHER'S NAME First James Henry Middle Hutson Last Hutson			15. MOTHER'S MAIDEN NAME First Amelia Middle Higdon Last Higdon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. 219-10-8974		17. INFORMANT Address Mrs. H. Vernon Hutson, Bozman, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Coronary Artery, Heart 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO, OR AS A CONSEQUENCE OF (c) -----									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6 Feb , 19 68 , to 8 Feb , 19 68 , that (I) (we) last saw the deceased alive on 6 Feb , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Lane Wroth, M.D.		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) R. LANE WROTH, M. D.		22e. ADDRESS St. Michaels, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb 11, 1968		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION (City or Town) (County) (State) Easton, Maryland			
24. FUNERAL DIRECTOR James E. Leonard, St. Michael, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Samuel C. Jones			2a. DATE OF DEATH Month 2 - Day 2 - Year 1968			2b. HOUR 12A.M.			
3. SEX MALE		4 RACE WHITE		5 DATE OF BIRTH JUNE 15, 1892		6 AGE (in years last birthday) 75 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md			
10. CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) WATERMAN		12b. KIND OF BUSINESS OR INDUSTRY SEAFOOD			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN NEAVITT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER —	
14. FATHER'S NAME First Middle Last GUSTAVUS JONES			15. MOTHER'S MAIDEN NAME First Middle Last EVELYN SUTTON HUNT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. —		17. INFORMANT MRS. RUTH S. JOHNSON, NEAVITT, MD		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) central thrombosis 4557 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 332X (b) atherosclerotic cerebrovasc DUE TO, OR AS A CONSEQUENCE OF (c) —								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Influenza, Bronchitis, pneumonia, embolism									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1953 , 19 — , to 2-2-68 , that (I) (we) last saw the deceased alive on 2-1-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ray M. Beeser				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-2-68			
22d. PHYSICIAN'S NAME (Type) Ray M. Beeser				22e. ADDRESS St. Michael's					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE FEB 5, 1968		23c. NAME OF CEMETERY OR CREMATORY NEAVITT CEMETERY		23d. LOCATION (City or Town) (County) (State) NEAVITT, MARYLAND			
24. FUNERAL DIRECTOR Stanison E. Leonard		ADDRESS St. Michael's, Md		25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE Michael J. Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

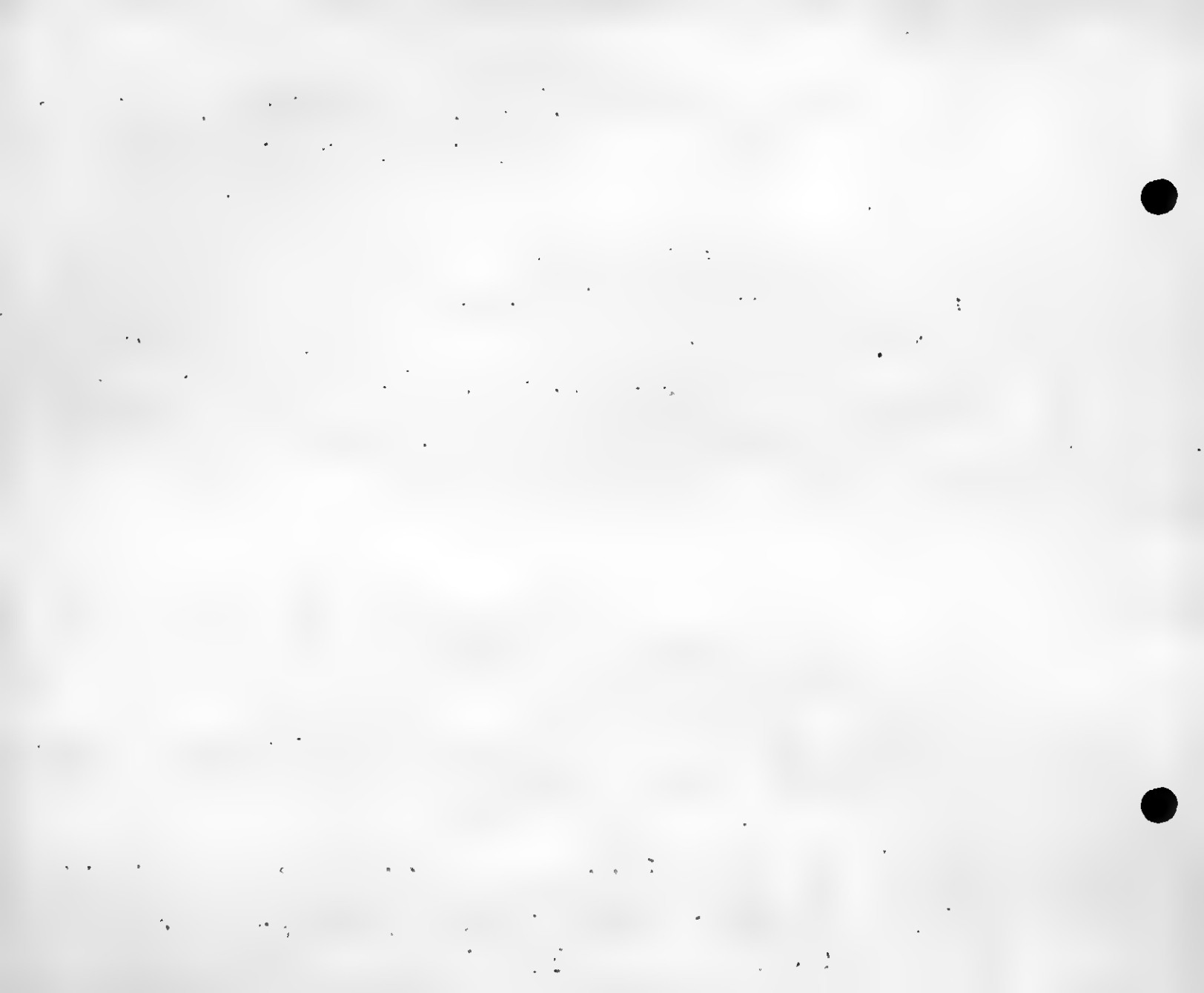
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03175

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Edna Lyon Kehm			2a. DATE OF DEATH Month Day Year Feb. 4 68			2b. HOUR 6:00 P.M.			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH April 13, 1878		6. AGE (in years last birthday) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE in the PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) WIFE		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland		13b. COUNTY Queen Anne's (Queenstown)		13c. CITY OR TOWN Easton		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last William H. Lyon			15. MOTHER'S MAIDEN NAME First Middle Last KATHERINE BREAKEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 220-44-8047		17. INFORMANT Niece Address Mrs. Ruth L. Thompson, GRASONVILLE Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 4-6-68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-29, 1968 , to 2-3, 1968 , that (I) (was) last saw the deceased alive on 2-3-68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.									
22b. SIGNATURE Stephen P. Carney		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-7-68			
22d. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.		22e. ADDRESS P.O. Box 929, Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Feb. 7, 1968		23c. NAME OF CEMETERY OR CREMATORY CENTERFIELD CEMETERY		23d. LOCATION (City or Town) (County) (State) Centerville P.A.C. Md.			
24. FUNERAL DIRECTOR James D. Barton Jr.		ADDRESS Barton Bco, Centerville Md.		25a. REC'D BY REGISTRAR DATE FEB 9 1968		25b. REGISTRAR'S SIGNATURE [Signature]			

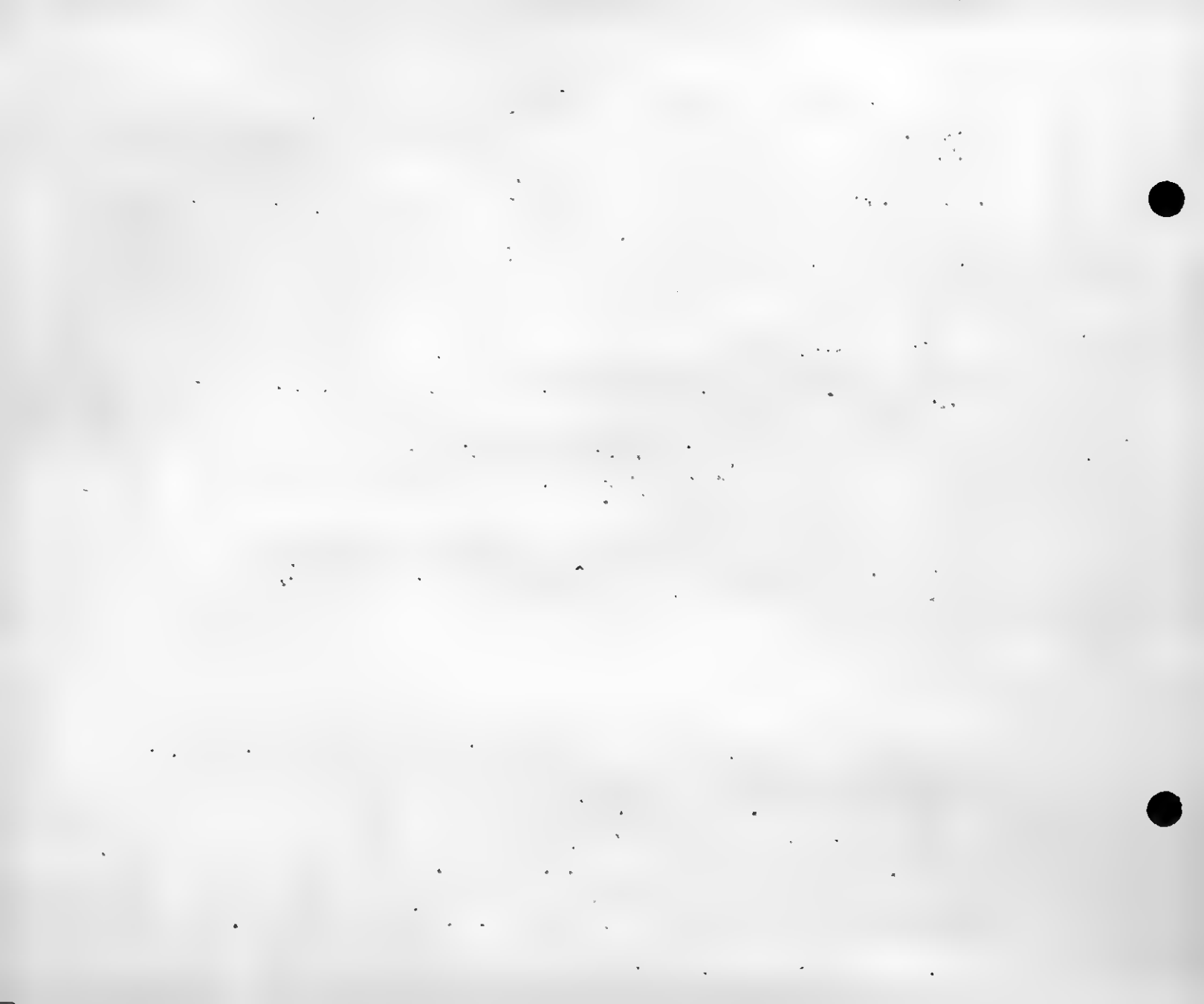


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Item 6 Film G398 3/1/68 kk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Charles E. H. Madary</i>			2a DATE OF DEATH Month <i>2</i> Day <i>27</i> Year <i>68</i>			2b HOUR <i>8:35</i> M					
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>10-22-86</i>		6 AGE (In years last birthday) <i>81 3/4</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT Eastm</i> Md					
10 CITY OR TOWN OF DEATH <i>Eastm</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>RET</i>			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>MARYLAND</i>			13b COUNTY <i>TALBOT</i>			13c CITY OR TOWN <i>ST. MICHAELS</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>106 E. CHESTNUT ST.</i>	
14 FATHER'S NAME First Middle Last <i>ANTHONY MADARY</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>IDA SNYDER</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO. <i>215-03-4796</i>			17 INFORMANT <i>CHARLES R. MADARY, EASTON, M.D.</i>			Address <i>Box 338</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic inflammation of Colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>12-38</i> (b) <i>Chronic inflammation of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>7 years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (b) <i>Chronic obstructive Pulmonary Disease</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>7-5</i> , 19 <i>64</i> , to <i>27 Feb</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-27</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R. Lane Wroth</i>						22c. DATE SIGNED <i>2-28-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i> M.D.						22e. ADDRESS <i>St. Michaels, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>Mar 1, 1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>David Ridge Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Pikesville, Maryland</i>		
24. FUNERAL DIRECTOR <i>Samuel Leonard, St. Michaels, Ind</i>						25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE <i>MAR 4 1968</i>											

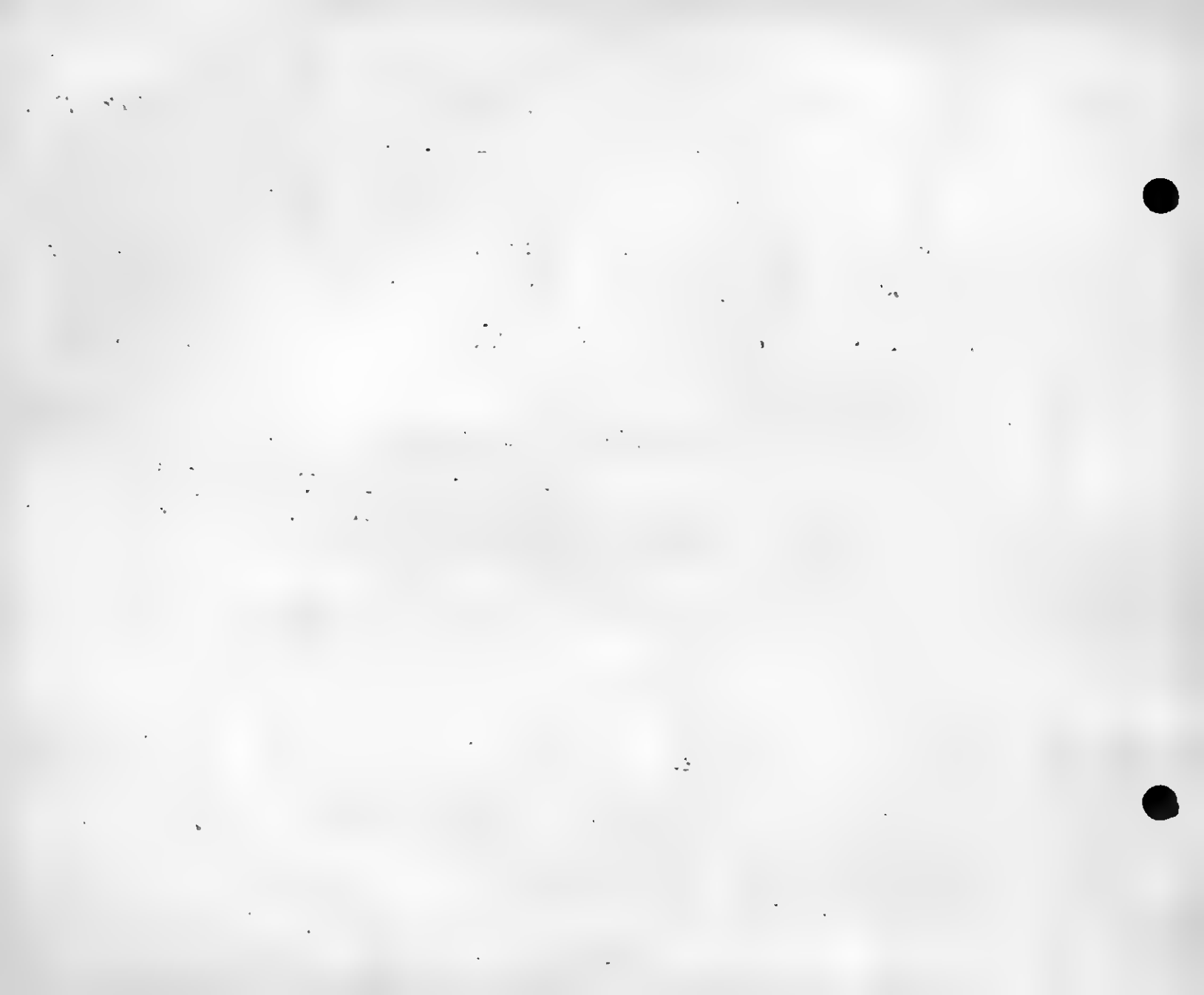


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VR 4-1-68
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR Min		
MARY					MELVIN	Feb. 27 1968			12 25 AM		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
Female		White		12-30-1879		72 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
DEL.		USA				Talbot Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			House in the Pines			ED+103			NEWSPAPER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD			CAROLINE			DENTON					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
WILLIAM SHEPARD CROUSE			ROSETTE			MOURER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Chronic brain syndrome due to										2	
DUE TO, OR AS A CONSEQUENCE OF cerebral arteriosclerosis,											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF manifested by aphasia											
(c) and progressive cachexia											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
+ X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 1962, to Feb. 27, 1968, that (I) (we) last saw the deceased alive on 2-14-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert W. Trever, M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-27-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			MARCH 1, 1968			DENTON			DENTON CAR. MD.		
24. FUNERAL DIRECTOR Charles Moore Denton Md.						25a. REC'D BY REGISTRAR DATE MAR 5 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

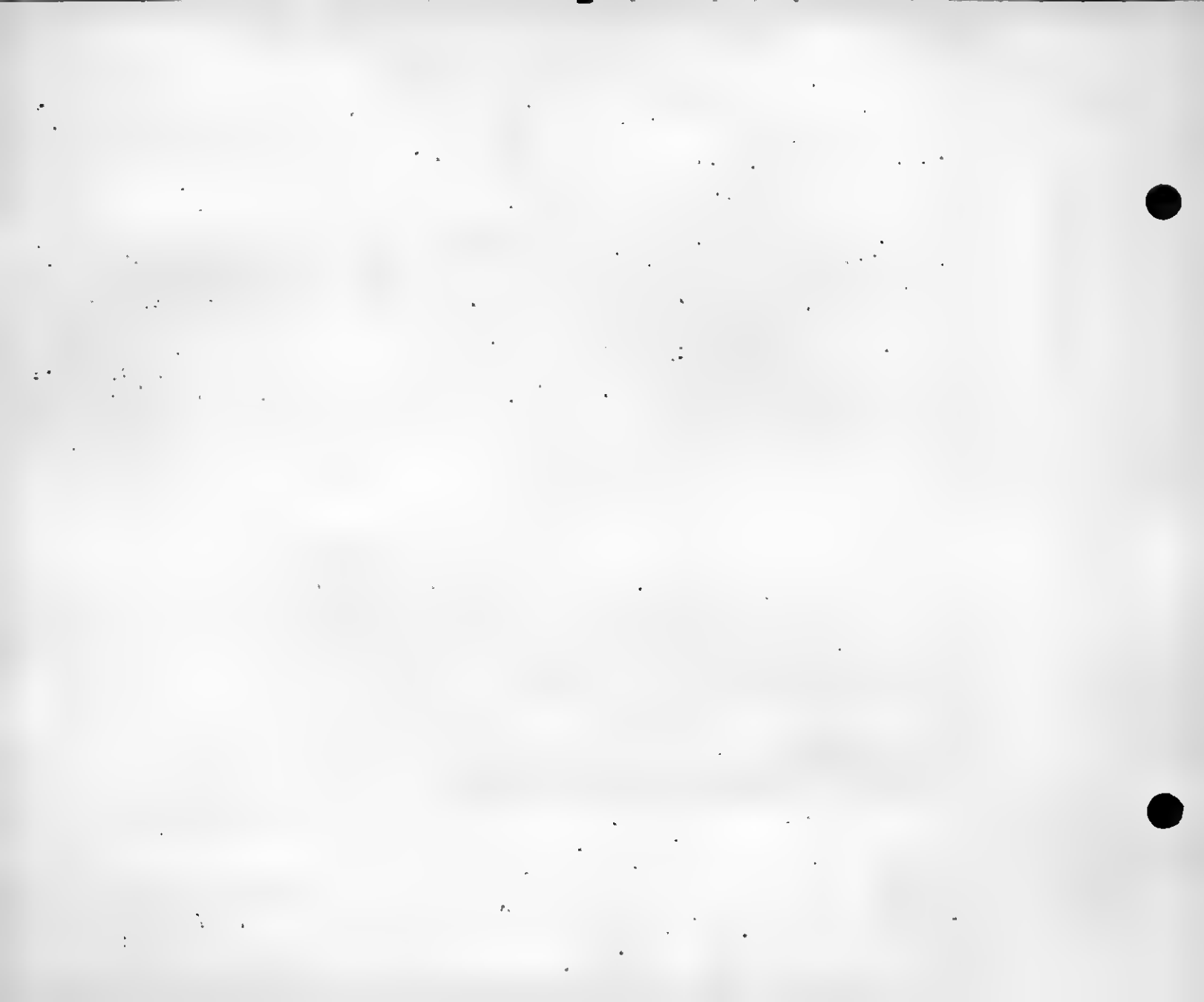


CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Luther Herman Meredith</i>			2a. DATE OF DEATH Month <i>Feb</i> Day <i>19</i> Year <i>68</i>			2b. HOUR <i>7:55</i> AM	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>JUNE 20 1880</i>		6. AGE (In years last birthday) <i>87</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Independent Agent</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>GENERAL INSURANCE</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Centerville</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>111 CHESTERFIELD AVE.</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>T.</i> Last <i>Meredith</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>-</i> Last <i>Dyott</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown? <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-32-0536</i>		17. INFORMANT <i>NIECE</i>		Address <i>2511 MAPLE AVE. WILMINGTON, DEL.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>493X</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic lymphatic leukemia, ASCVD, Diabetes</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>19 Feb</i> , 19 <i>68</i> , to <i>19 Feb</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>19 Feb</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carnev</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-20-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carnev</i>				22e. ADDRESS <i>M.D. Easton, Maryland</i>		22f. DATE <i>2/20/68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Feb. 22, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chesterfield Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Centerville D.A.C. Md</i>	
24. FUNERAL DIRECTOR <i>Jamie H. Bartsch - Bartsch Bros. - Centerville, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Ella Mooney</i>						2a. DATE OF DEATH Month <i>2</i> Day <i>29</i> Year <i>68</i>			2b. HOUR <i>11:05</i> M		
3. SEX <i>Female</i>		4. RACE <i>Col Negro</i>		5. DATE OF BIRTH <i>March 4, 1897</i>			6. AGE (in years last birthday) <i>70</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of work week, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>20 Thoroughgood Lane</i>			
14. FATHER'S NAME First <i>James Henry</i> Middle <i>Winters</i> Last <i></i>				15. MOTHER'S MAIDEN NAME First <i>Harriet</i> Middle <i></i> Last <i>Wilson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO. <i>216 18 8353</i>		17. INFORMANT Address <i>Mrs. Beulah Smith, Baltimore, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute left ventricular failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>42 yrs</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>10 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>diabetes mellitus</i>											
19a. DATE OF OPERATION <i>26 Feb 68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bypass of Reel</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Apr</i> , 19 <i>65</i> , to <i>29 Feb</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>29 Feb</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i> DEGREE <i>M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>3-1-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>				22e. ADDRESS <i>Easton, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Coppersville</i>		23d. LOCATION (City or Town) (County) (State) <i>Coppersville Talbot Md.</i>					
24. FUNERAL DIRECTOR <i>BE Dashiell</i>				426 DOVER ST. EASTON, Md.				25a. REC'D BY REGISTRAR <i>MAK</i> 5 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03160

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03164

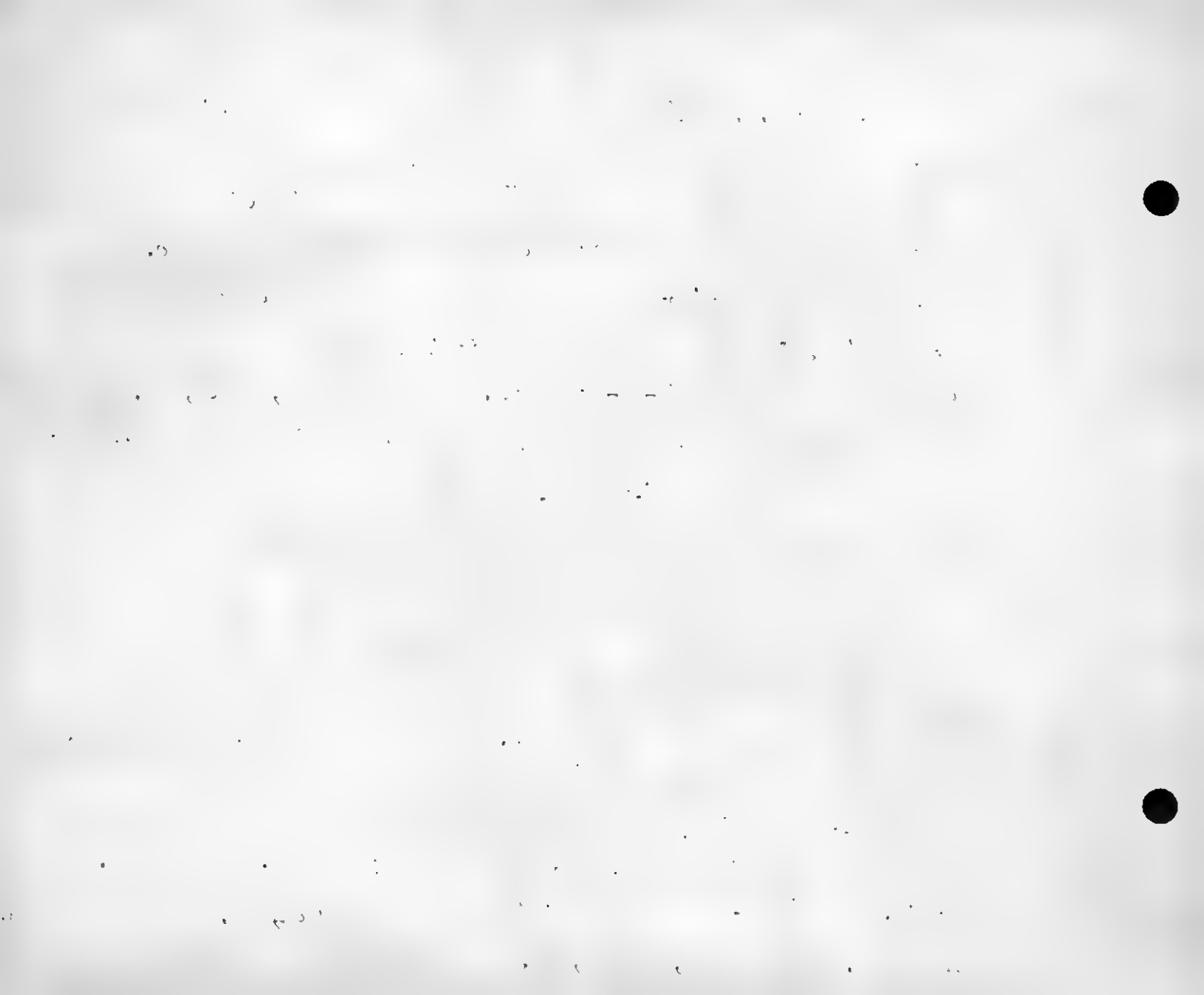
1. DECEASED NAME (Type or print) JENNIE			First Middle Last MOELLER			2a. DATE OF DEATH Month Day Year 2-7-68			2b. HOUR 24 M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH Nov 5, 1880			6. AGE (in years last birthday) 87 YRS.		
7a. BIRTHPLACE (State or foreign country) BROOKLYN, N.Y.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH TALBOT Md.		
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. rad.) NOT EMP			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) MARYLAND			13b. COUNTY TALBOT			13c. CITY OR TOWN ST. MICHAELS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER WILLOW ST.			14. FATHER'S NAME First Middle Last JOHN MOELLER			15. MOTHER'S MAIDEN NAME First Middle Last EMMA MEYER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO —			17. INFORMANT MRS. GEORGE WESTFALL			Address HUNTINGTON, N.Y.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 331											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1 pm , 19 68 , to 7 pm , 19 68 , that (I) (we) last saw the deceased alive on 6 Feb , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thurston Harrison						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7 Feb 68		
22d. PHYSICIAN'S NAME (Type) THURSTON HARRISON						22e. ADDRESS Cabin Key Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb 9, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery			23d. LOCATION (City or Town) (County) (State) St. Michaels Md.		
24. FUNERAL DIRECTOR Harrison E. Leonard, St. Michaels, Md.						25a. REC'D BY REGISTRAR DATE FEB 13 1968			25b. REGISTRAR'S SIGNATURE Charles J. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

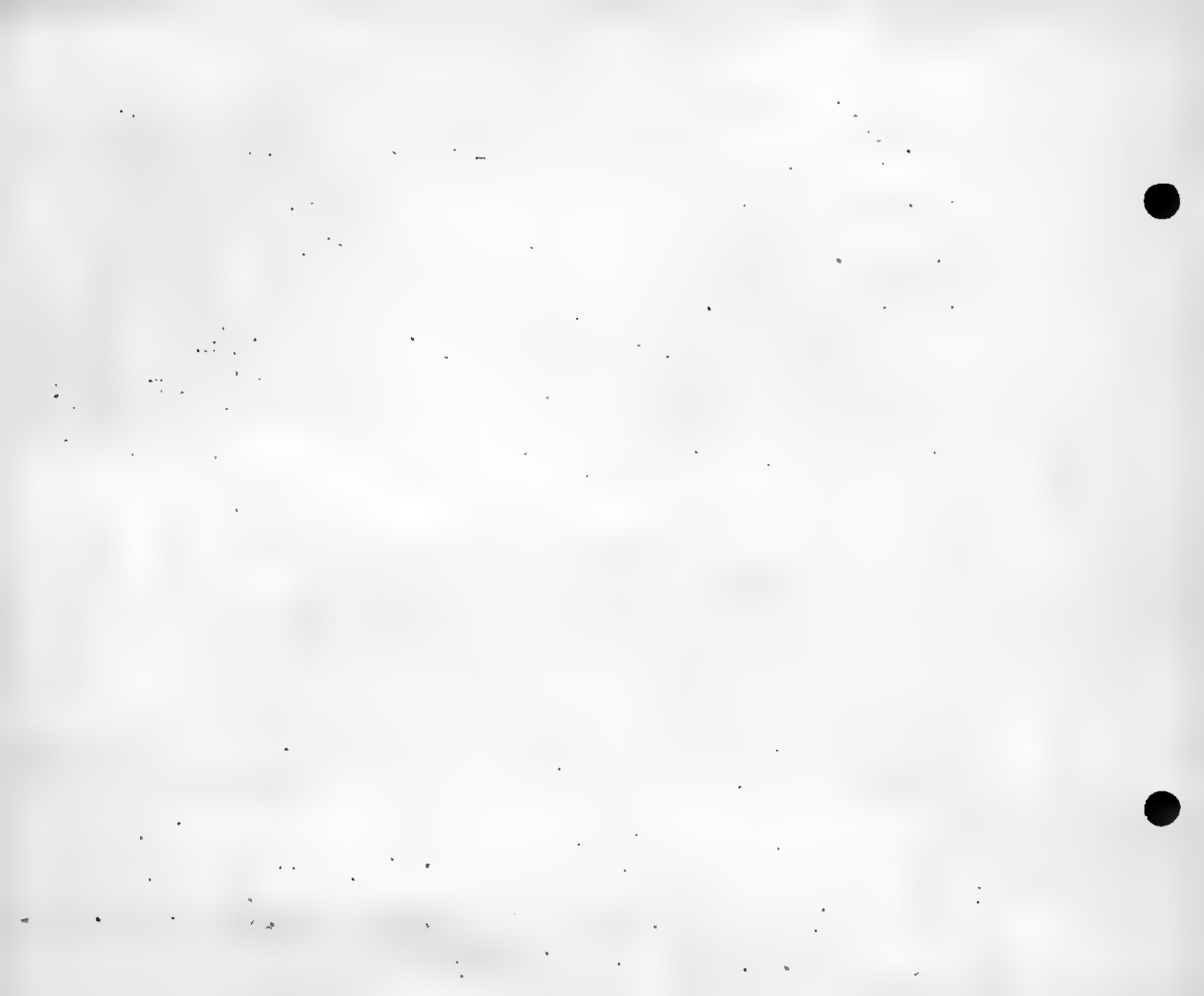
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <i>Herbert W. H. Mueller</i>			2a. DATE OF DEATH <i>2</i> Month <i>13</i> Day <i>1968</i> Year			2b. HOUR M				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10/17/1885</i>		6. AGE (In years last birthday) <i>82</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i>				
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>704 Dover Road</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Routeman for Ice Co.</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>704 Dover Road</i>	
14. FATHER'S NAME First Middle Last <i>Frederick W. Mueller</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Minnie Osterman</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>218-09-6297</i>		17. INFORMANT Address <i>Mrs. Herbert Mueller, Easton, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Under 10 min.</i> <i>1962</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4200 None</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 6, 1962</i> , to <i>2-13, 1968</i> , that (I) (we) last saw the deceased alive on <i>1-21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert W. Trever, M.D.</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-15-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever, M.D.</i>					22e. ADDRESS <i>R.D. 3, Easton, Md. 21601</i>					
23a. BURIAL, CREMATION, REBURY <i>Buried</i>		23b. DATE <i>2/16/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>			23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>MURPHY E. NEWMAN & SON, Easton, Md.</i>					25a. REC'D BY REGISTRAR <i>FEB 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Hilda Pratt						Month Day Year		10:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		11-23-1876		77 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Mich.		U.S.C.				Talbot Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton, Md.		House In The Pines		None					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Dor & Secretary							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Adam Newgrecan			Beata Ohlson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
No					Mrs Mark Welsh, Secretary, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>								4 weeks	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
434									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>65</u> , to <u>2-28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Stephen P. Carney									2-29-68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Stephen P. Carney					Easton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/5/68		Clare		Clare Mich.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Doth. Thoroughly East New Market				MAR 7 1968		yuaner yang			



TO

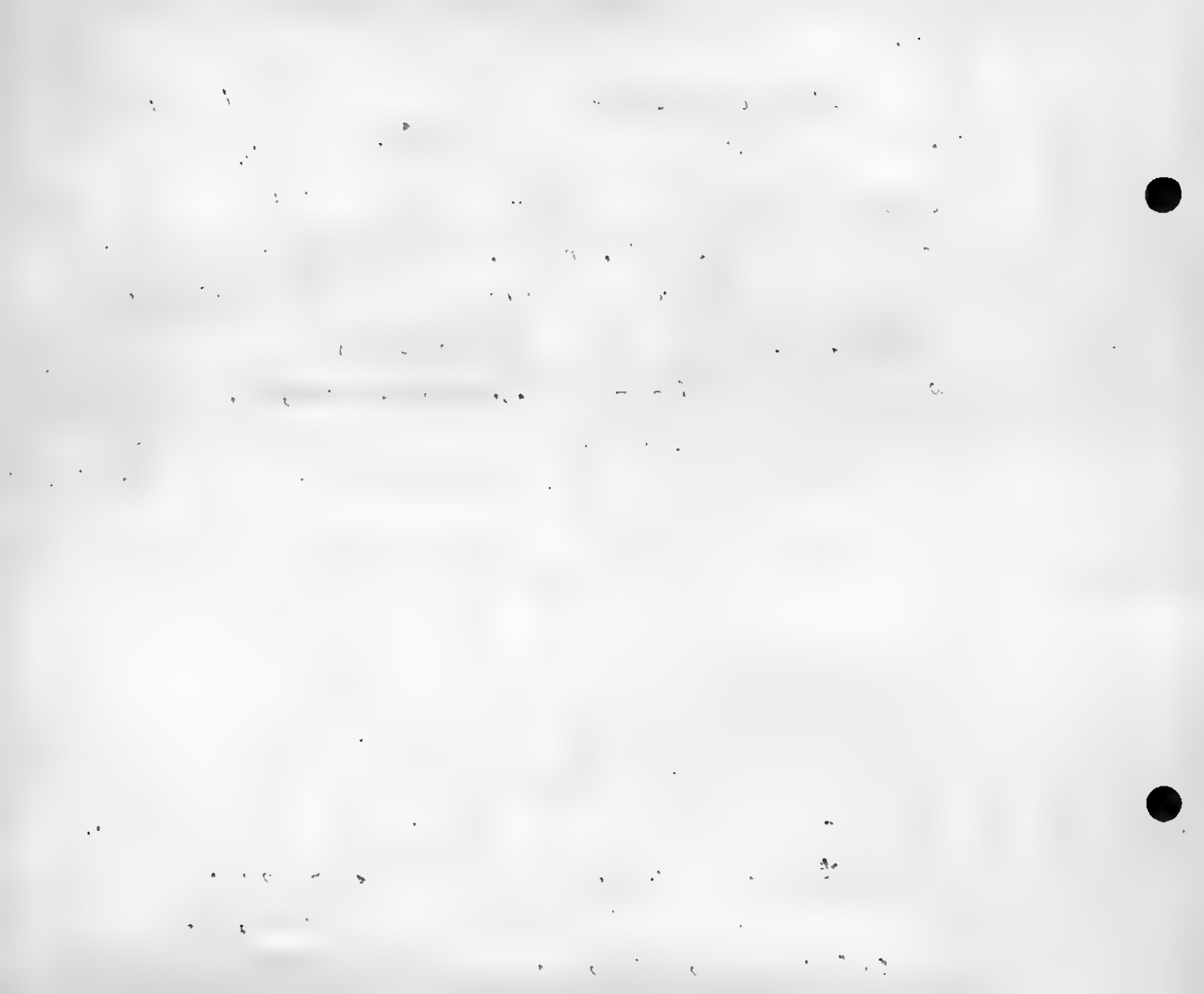
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Year		2b. HOUR	
John Wesley SETH JR.								2-10-1968		11		PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M		C		12-8-11		56 YRS		MONTHS		DAYS		Month		Day	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH							
Md		USA		WIDOWED		DIVORCED		TALBOT							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY									
EASTON		MEMORIAL													
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
MD		CAROLINE		RIDGELEY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
JOAN		W.		SETH				MARGARET						Mondray	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		218-16-8695		MRS. J. W. SETH, SR.		RIDGELEY MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Occlusion - recurrent		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
410				DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF											
		(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
		HOUR A.M. P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED		2-11-68											
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)							
Louis J. Neely		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type)		INEELTV for													
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
BURIAL		FEB 15, 1968		NEWTON N		TALBOT		MD.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Louis J. Neely & Son		Baltimore		FEB 16 1968		Charles J. J. J.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Miriam Leonette Seymour					2 Month 15 Day 1968		M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS		
Female	White		1/29/1884		84 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Talbot Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Trappe		Home of Mrs. and Mrs. Alex Green		Housework					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Talbot		Easton				11 Sycamore St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
William E. Ewing		Charlotte Days							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
no		218-05-77903		A. E. Seymour, Jr.		Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								} Unknown	
IMMEDIATE CAUSE (a) Senility									
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
334 X none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 11-29, 1965, to 2-15, 1968, that (I) (we) lost the deceased alive on 2-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
Robert W. Trever, M.D.		Robert W. Trever, MD.		RFD #3 Easton, Md.		2-19-68			
23a. BURIAL, CREMATION, REMAINS		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/17/1968		Spring Hill		Easton, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
MAURICE E. NEWMAN & SON, Easton, Md.				FEB 20 1968		Richard Jones			

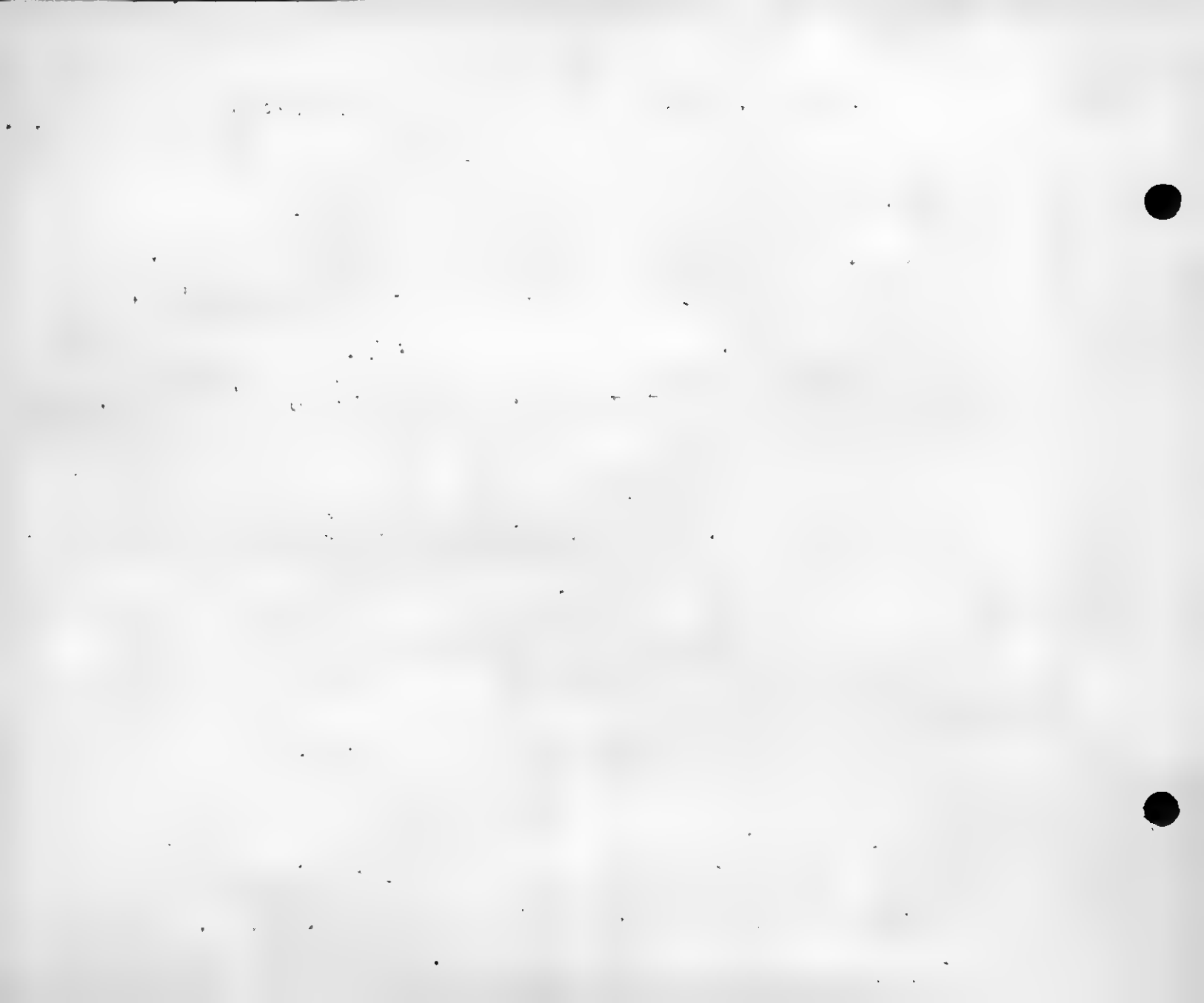


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VR A15 (2)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
0316													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR		
ELEANOR SHANNAHAN									2-22-1968		7:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 2 YEARS HOURS MIN.		
FEMALE		WHITE		8-26-1885			82 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
Maryland		USA					TALBOT Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work nglife, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
EASTON, MD.			HOUSE IN THE PINES			Bookkeeper Hardware							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Talbot			Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		105 Brookletts Ave.			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
James Edward Shannahan									Emma Wrightson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no						220-32-96184		J. Graham Shannahan, Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Heart Failure										Days.			
DUE TO, OR AS A CONSEQUENCE OF													
(b) Atherosclerotic and													
DUE TO, OR AS A CONSEQUENCE OF													
(c) Hypertensive Cardiovascular Disease										yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Fracture, RT. femur - 2 mos.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
			HOUR A.M. Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						5/3			60 2/22 68				
22a. I certify that (I) (this hospital) attended the deceased from 5/3, 1968, to 2/22, 1968, that (I) (we) lost saw the deceased alive on 1/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
S. Kreck			2-23-68										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS										
S. Kreck JR			Easton, Md										
23a. BURIAL, CREMATION, REINTERMENT			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			2/24/1968		Spring Hill			Easton, Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Maurice L. Newman			Easton, Md			FEB 27 1968							

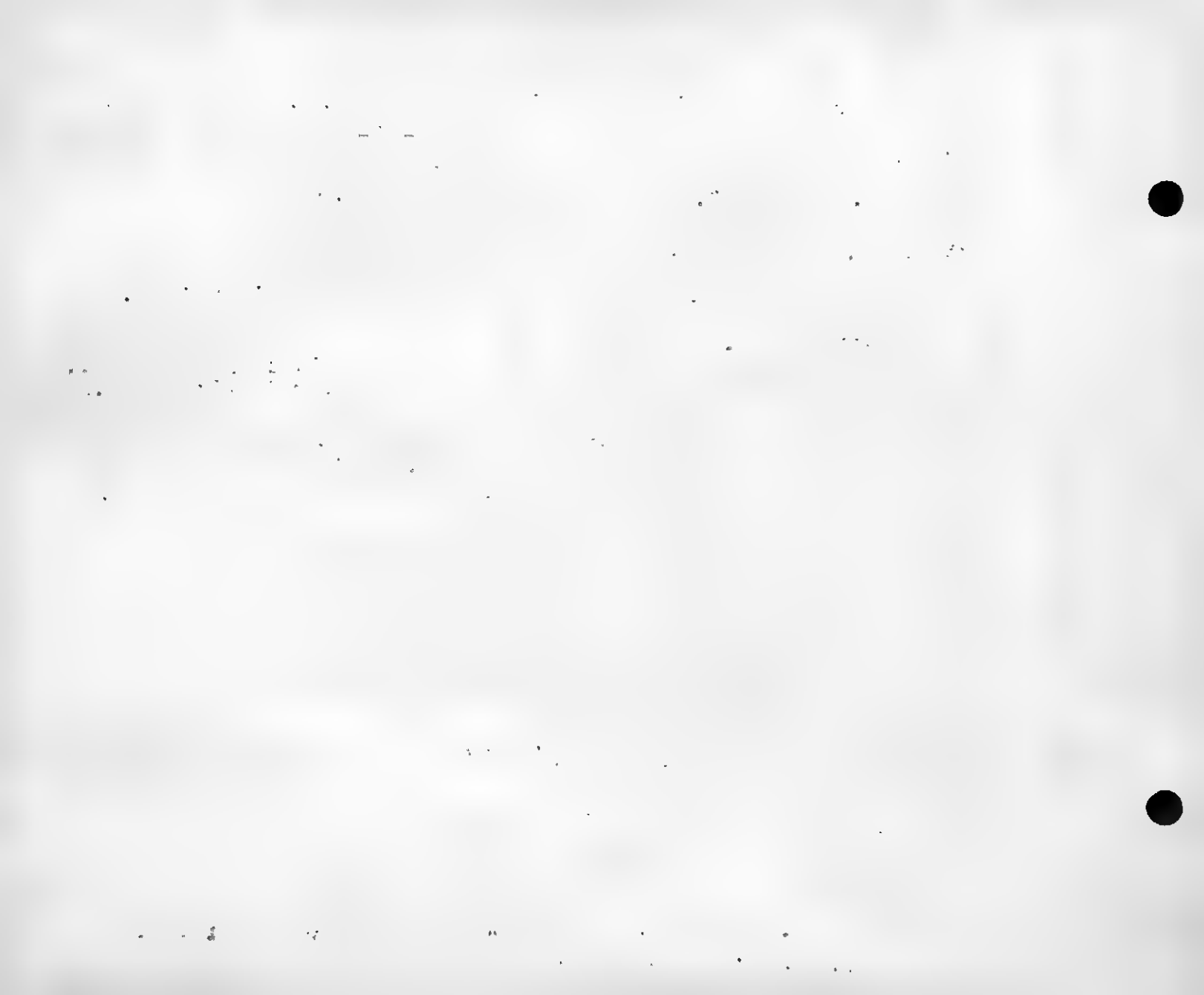


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Edith Mathews Smith			2a. DATE OF DEATH Month 29 Day 28 Year 1968			2b. HOUR 12:05 M			
3 SEX Female		4. RACE White		5. DATE OF BIRTH 2-25-1883		6 AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) West Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot			
10. CITY OR TOWN OF DEATH Easton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House In The Pines		12a. USUAL OCCUPATION (Kind of work done during most of workable life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 701 Locust St.	
14. FATHER'S NAME First Daniel Middle H. Last Mathews			15. MOTHER'S MAIDEN NAME First Lucy Middle Charlton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT 11612 Edwin Ave., Glenn S. Smith, Philadelphia, Pa. 19116				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Aplastic anemia DUE TO, OR AS A CONSEQUENCE OF (c) last Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 66 to 28 Feb. , 19 68 , that (I) (we) last saw the deceased alive on Feb. 21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen O. Canby				DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-29-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 3, 1968		Dorchester Memorial Park, Cambridge, Md.		Cambridge, Md.			
24. FUNERAL DIRECTOR Kenneth R. Thomas Jr.				ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR DATE MAR 5 1968		25b. REGISTRAR'S SIGNATURE John L. Judge	

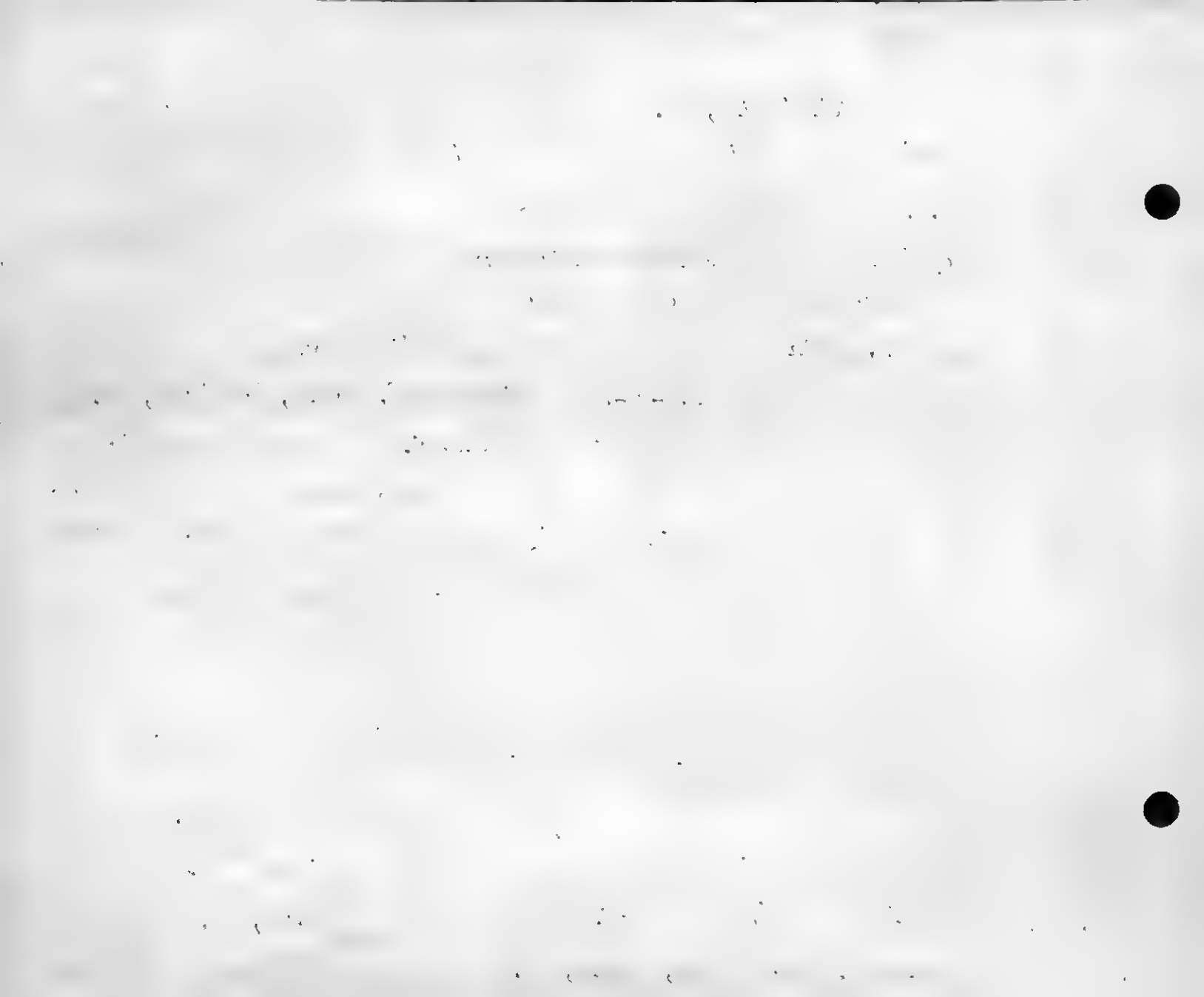


CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>John Swaine, Sr.</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>1</i> Year <i>1968</i>			2b. HOUR M			
3 SEX <i>Male</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>11/1/1889</i>		6 AGE (In years last birthday) <i>78</i> YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
10. CITY OR TOWN OF DEATH <i>Royal Oak</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Pleasant Points Farm</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Farming</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Royal Oak</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14 FATHER'S NAME First Middle Last <i>Joe W. Swaine</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Connelia Bensinger</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>215-36-1805</i>		17. INFORMANT Address <i>Miss Mary C. Swaine, Royal Oak, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Cor Pulmonale</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Obstruct. Pulm. Emphysema</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>YRS.</i> <i>YRS.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic Brain Syndrome due to cerebral atherosclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <i>64/19 51 2/1 68</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>11/15 1968</i> to <i>2/1 68</i> , that (I) (we) last saw the deceased alive on <i>11/15 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>S. KRECH JR.</i>		22c. DATE SIGNED <i>2/2/68</i>		22d. PHYSICIAN'S NAME (Type) <i>S. KRECH JR.</i>		22e. ADDRESS <i>EASTON, Md</i>			
23a. BURIAL, CREMATION, or other disposition <i>Buried</i>		23b. DATE <i>2/3/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>MURPHY E. NEWMAN & SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

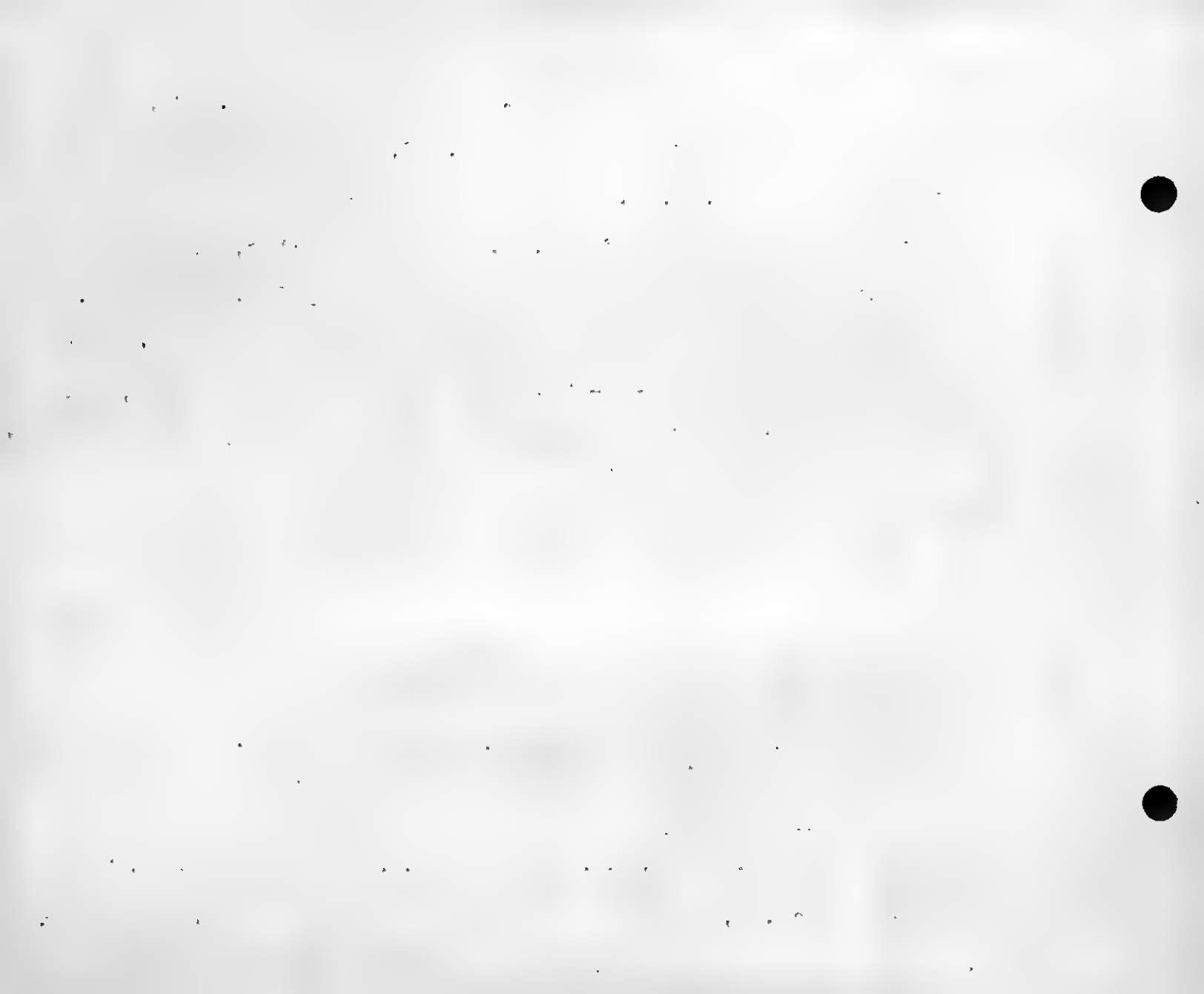
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Ida			May			Warner		Feb. 27, 1968 M	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Dec. 23, 1884		83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. IF UNDER 24 HRS. HOURS MIN.	
Maryland		U. S. A.				Talbot			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Trappe		Home of Mrs. A. Green		Housewife, retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Talbot		Easton				310 S. Aurora St.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Thomas Willis			Elizabeth Ellen Roberts						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
no		819-07-9427		James Edgar Warner, Sherwood, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Progressive cerebral arteriosclerosis</u>									5 years
437.7 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1965, to Feb. 27, 1968, that (I) (we) last saw the deceased alive on Feb. 20, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Stephen P. Carney								2-28-68	
22d. PHYSICIAN'S NAME (Type)		Stephen P. Carney, M.D.		22e. ADDRESS		P.O. Box 929, Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		Mch. 1, 1968		Spring Hill		Easton Talbot Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
R. H. Clark		Easton Md		DAMAR 4 1968		Charles J. Jones			



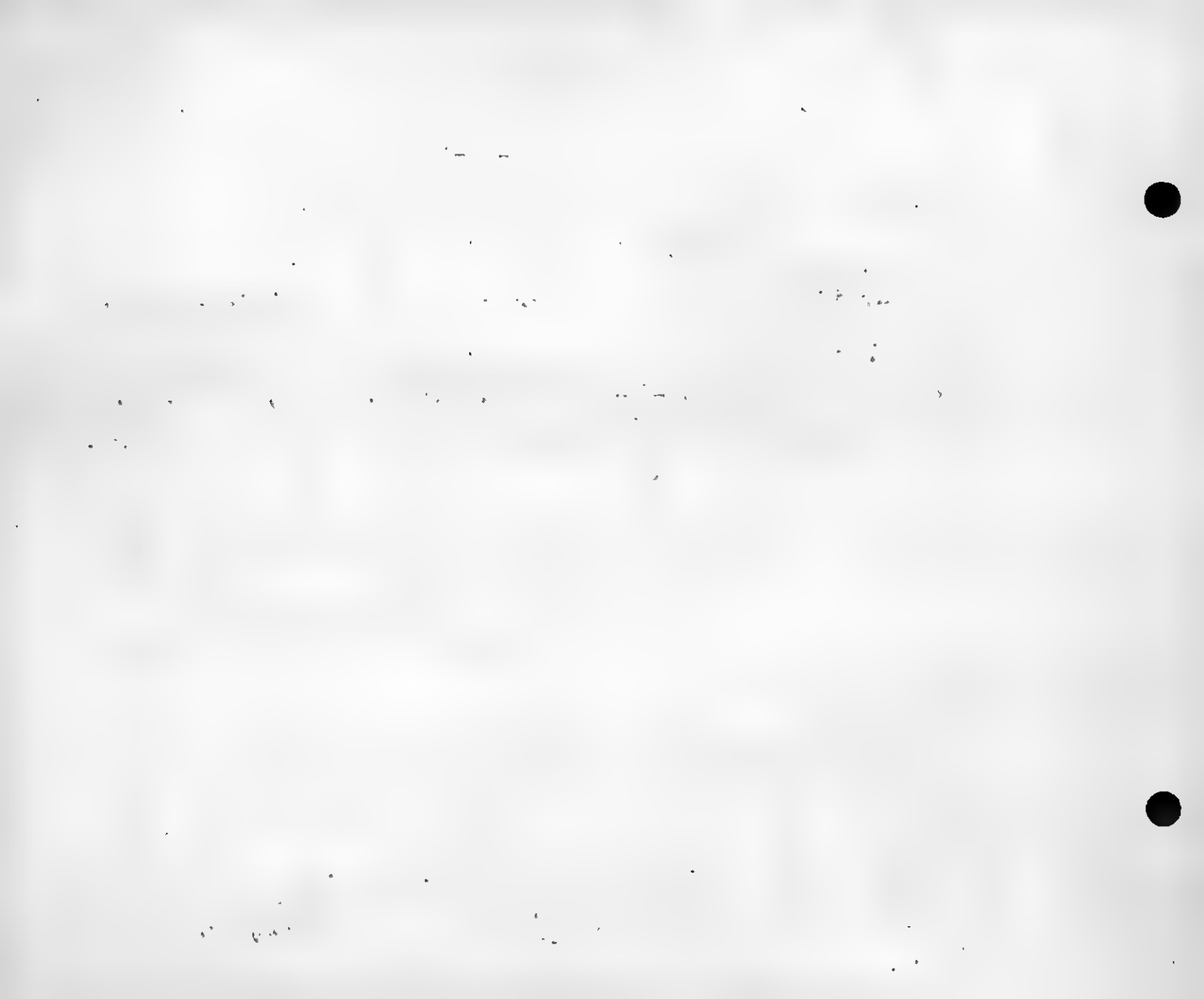
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) James M. Warner			2a. DATE OF DEATH Month 2 Day 12 Year 1968			2b. HOUR 8 15 P M	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 3-30-1883		6 AGE (in years last birthday) 84 YRS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.	
10 CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Game Warden		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 303 S. Hanson St.							
14 FATHER'S NAME First Middle Last Alfred T. Warner			15 MOTHER'S MAIDEN NAME First Middle Last Sara Jane Fox				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 215-38-0003		17 INFORMANT Mrs. James M. Warner, Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Barbiturate poisoning 4 x 5 X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 68 , to 12/16 , 19 68 , that (I) (we) lost the deceased alive on 12/16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thorston Harrison M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 13 Feb 68	
22d. PHYSICIAN'S NAME (Type) THORSTON HARRISON		22e. ADDRESS Easton, Maryland					
23a. BURIAL, CREMATION, REINTERMENT Buried		23b. DATE 2/15/1968		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or Town) (County) (State) Easton, Md.	
24. FUNERAL DIRECTOR Maurice E. Newman, Easton				25a. REC'D BY REGISTRAR DATE FEB 14 1968		25b. REGISTRAR'S SIGNATURE	

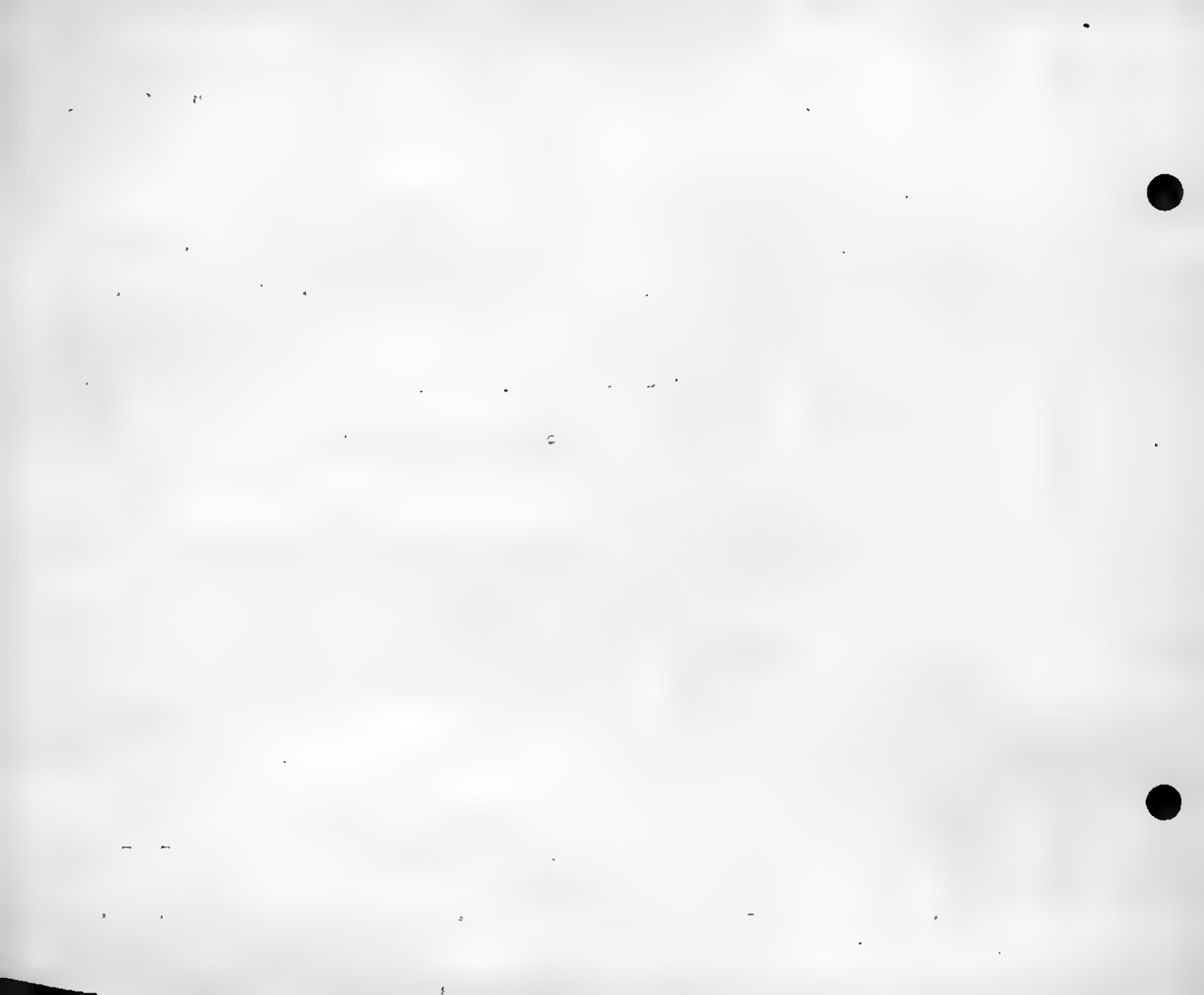


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First MORRIS		Middle MICKRIS		Last WRIGHT		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Year 1968 Day 18	
3. SEX male	4. RACE white	5. DATE OF BIRTH 12/28/1897	6. AGE (in years last birthday) 70 YRS	7. UNDER 24 HRS MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month _____ Day _____ Year 19	2d. HOUR M
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH TALBOT		Md	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) business man & horseman		12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER E. Central Ave.	
14. FATHER'S NAME First Peter W. Middle Wright Last Wright				15. MOTHER'S MAIDEN NAME First Anna Alice Middle Hubbard Last Hubbard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 218-36-6624		17. INFORMANT ADDRESS Mrs. June Nordberg Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 431.7 IMMEDIATE CAUSE (a) Cerebral hemorrhage-recurrent DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from; Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE James O. Welch		EXAMINER'S NAME (Type) welty		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> for DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 2-19-68			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2/21-68		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		23d. LOCATION (City or Town) (County) (State) Federalsburg, Md.			
24. FUNERAL DIRECTOR Charles J. ...				ADDRESS Federalsburg, Md.		25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 2a Film G398 2/28/68

03173

1. DECEASED-NAME (Type or Print) THOMAS			First Middle Last LEE			Last WRIGHT SR.			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 2 9 19 68			2b. HOUR M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUG 19, 1908		6. AGE (In years) YEARS 59		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year FEB 9 1968		2d. HOUR 40A	
7a. BIRTHPLACE (State or foreign country) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH TALBOT						
1d. CITY OR TOWN OF DEATH EASTON				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SHILL DOLLER				12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY CAROLINE / GREENSBORO				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last FRANK WRIGHT				15. MOTHER'S MAIDEN NAME First Middle Last MAE ROE				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO							
16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS J. LEE WRIGHT, JR. MILFORD, DEL.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 411.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Probable Bundle Branch Block (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Lewis O. Welty				CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 2-9-68							
EXAMINER'S NAME (Type) WELTY				ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE FEB 12, 1968				23c. NAME OF CEMETERY OR CREMATORY DENTON				23d. LOCATION (City or Town) (County) (State) DENTON CAR. MD.			
24. FUNERAL DIRECTOR IRVING L. MOORE				ADDRESS DENTON MD.				25a. REC'D BY REGISTRAR DATE FEB 16 1968				25b. REGISTRAR'S SIGNATURE Charles Jones			

1961

THOMAS

LEE

WHITE

WHITE

RENEWAL

RENEWAL

X

XX

1961-5

1961-5

1961-5

1961-5

1961-5

1961-5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03192										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03174									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
THOMAS OLIN WYATT										Month 2 Day 11 Year 68										7:30 A.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
MALE			WHITE			December 7, 1885			82 YRS.			MONTHS			DAYS														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Maryland			USA						TALBOT Md.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
EASTON			HOUSE IN THE PINES			Retired Night Watchman			Factory																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER																	
Maryland			Caroline			Federalsburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			103 South Main Street																	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last					First Middle Last																								
John Wyatt					Julia Moore																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT Address																			
No					217-16-9427					Ruth M. Wyatt, Federalsburg, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Uremia</u>															6 months														
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															may years														
(b) <u>Arteriosclerosis</u>																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)																													
<u>4500</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
										YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
					HOUR A.M. Month Day Year P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					Street or R.F.D. No. City or Town County State														
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>20 Jan, 1968</u> , to <u>11 Feb, 1968</u> , that (I) (we) lost the deceased alive on <u>9 Feb, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED									
<u>Stephen P. Carney</u>																				<u>2-12-68</u>									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
Stephen P. Carney, M.D.										P.O. Box 929, Easton, Md. 21601																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Feb. 14, 1968					Kingsley Cemetery					Chester, Maryland														
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
<u>J. J. Hampton</u>										<u>Federalsburg, Md.</u>					DATE <u>FEB 16 1968</u>					<u>Charles Judge</u>									

